Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

CHILD'S INFORMATION

Today's Date_____ Referred By_____

Name_____ Nickname_____
Last Name First Name Middle Initial

Address_____City_____ Zip_____

Birthdate_____ Phone (H) _____ (Cell) _____

School Name/City_____

Who is Responsible for Making Appointments? _____

Phone (H) _____ (W) _____ (Cell) _____

E-Mail Address_____

Appointment Confirmation Call Preference: Home ☐ Work ☐ Cell ☐

EMERGENCY CONTACT

Name_____ Relation_____

Phone (H)_____ (W) _____ (Cell) _____

PRIMARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____ Phone(H)_____

Employer_____ Occupation_____ Phone(W)_____

Insurance Carrier_____ Phone_____ Group#_____

Address of Carrier_____

SECONDARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____ Phone(H)_____

Employer_____ Occupation_____ Phone(W)_____

Insurance Carrier_____ Phone_____ Group#_____

Address of Carrier_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DENTAL HISTORY

Why did you bring the child to the dentist today?

_____

Are they currently in pain? Yes No

Do they require antibiotics before dental treatment? Yes No

Their current dental health is? Good Fair Poor

Do they floss daily? Yes No Do they brush daily? Yes No

Are any teeth sensitive to heat, cold, or anything else?

_____

Previous Dentist_____ City_____

Last Visit Date_____ Last X-rays Taken_____

Has the child ever had a serious / difficult problem associated with previous dental work? Yes No

MEDICAL HISTORY

Physician's Name_____

Phone Number_____ Last Visit Date_____

List any prescription or over the counter drugs the child is currently taking _____

_____

Kaiser Number_____

Does / Did the child have any of the following habits?

Lip sucking / Biting Yes No

Nursing Bottle Habits Yes No

Nail Biting Yes No

Thumb / Finger Sucking Yes No

Was the child breast fed? Yes No

Does your child have or has your child experienced any of the following? Please circle:

Y N Abnormal Bleeding
Y N Aids/HIV Positive
Y N Anemia
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Dental Anxiety
Y N Diabetes
Y N Dry Mouth
Y N Epilepsy
Y N Exposed to HIV, but negative
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Measles
Y N Mononucleosis
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)
Y N Other
_____

Please list any serious medical condition(s) that the child has had:_____

Is the child allergic to any of the following? Please circle:

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other
_____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. It will be used by the dentist to help determine appropriate and healthful dental treatment. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services the child may need. I authorize the insurance company indicated on the form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not paid by insurance. I understand that missed appointments and appointments cancelled without 24 hours' notice are subject to a fee of $35.00 per appointment.

Signature of Patient or Guardian_____ **Date**_____

Doctor's Signature_____ **Date**_____

Medical Update (for office use only):

DATE	EXCEPTIONS	PARENT/GUARDIAN SIGNATURE	REVIEWED BY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Office Use Only:_____